MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (930)

CERTIFICATE OF DEATH

08977

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Rocks
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Parke
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John C Ayres

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widow

6.(b) Name of husband or wife: Ella O Ayres
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 4 - 1862

8. AGE: Years	Months	Days	If less than one day
83			..... hrs. ..... min.

9. Birthplace: Rocks (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: John T Ayres
13. Birthplace: Md

MOTHER
14. Maiden name: Ann E Hazlett
15. Birthplace: Md.

16. Informant: Mrs Ruth D Rutherford
Address: Rocks, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 2/45 (month) (day) (year)
Cemetery or crematory: Wm Watters Memorial
Location: Near Jarrettsville, Md
18. Funeral director: Dean & Foster
Address: Bel Air, Md
19. 9-31- 45 (Date rec'd by registrar) Priscilla Forwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 30, 1945, at 4 15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 1944, to Aug 30, 1945 and that I last saw h.. l.m. alive on August 29, 1945

Immediate cause of death: Pulmonary edema and heart failure after prolonged confinement to bed — DURATION: 24 hrs.

Due to: Hypertensive cardio-vascular disease — DURATION: Several years.

Due to:

Other conditions: Paralysis following cerebral hemorrhage — DURATION: 1 year.
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles A. Graff M.D. M. D. or other
Address: Jarrettsville, Md Date signed: 8-31-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

08078

Reg. Diat. No. 182

1. PLACE OF DEATH:
County Harford
City or town Rural - Bel Air
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Baldwin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Cora Baldwin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband ~~or wife~~ John R. Baldwin 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 2. 1870

8. AGE: Years	Months	Days	If less than one day
74	11	6	..... hrs. ..... min.

9. Birthplace Baldwin, Maryland (Town, county, and state)
10. Usual occupation House wife
11. Industry or business

FATHER
12. Name Silas Baldwin
13. Birthplace Baldwin, Md.

MOTHER
14. Maiden name Susan Ashton
15. Birthplace Baldwin Md

16. Informant J. Rush Baldwin
Address Bel Air, R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 30 1945 (month) (day) (year)
Cemetery ~~or crematory~~ Rock Spring
Location Nr. Forest Hill, Md.

18. Funeral director Henry Jarrings Sons
Address Aberdeen, Md.

19. S. 28 1945 Priscilla Forwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1945, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 - 1940 to Aug 27 1945
and that I last saw her alive on Aug 27 1945

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE (3 Episodes)	5 da
Due to Hypertension - Cardiac Vascular Disease	15 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Willard P. Hudson M. D. or other
Address Forest Hill Md Date signed 8/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

08079

Reg. Dist. No. 4418

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Harford

City or town West Fairville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years, 6 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Harford

City or town Forest Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No. John R.F.D. No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Emma Long Barnett

3.(b) Social Security Number #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widowed

6.(b) Name of husband or wife William Henry Barnett

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 20, 1872

8. AGE: Years	Months	Days	If less than one day
72	9	0	..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name Robert L. Long

13. Birthplace Md.

MOTHER 14. Maiden name Elizabeth Jenkins

15. Birthplace Md.

16. Informant Mrs. Ruth A. Barnett

Address Joppa R.F.D. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 22, 1945 (month) (day) (year)

Cemetery or crematory Wesley Freedom Cem.

Location Eldersburg Carroll Co., Md.

18. Funeral director C. Harry Weer

Address Sykesville, Md.

19. Aug 21 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1945 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 18 1944 to August 20 1945 and that I last saw her alive on August 18, 1945

Immediate cause of death	DURATION
Carcinoma of Liver	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Clifford F. Hudson, M.D. M. D. or other

Address Fork, Md. Date signed 8/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 1180 445

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: 704 Lewis St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED.
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 704 Lewis St.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War #1

3.(a) FULL NAME Arthur Clayton Bauer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Alice Bauer
6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): May 5, 1900

8. AGE: Years	Months	Days	If less than one day
45	2	28	— hrs. — min.

9. Birthplace: Havre de Grace Md. (Town, county, and state)
10. Usual occupation: Steel Worker
11. Industry or business: U.S. Gov. Edgewood Arsenal

FATHER
12. Name: J. W. Bauer
13. Birthplace: Md.

MOTHER
14. Maiden name: Alice French
15. Birthplace: Md.

16. Informant: Mrs. Alice C. Bauer
Address: 704 Lewis St. City.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 6, 1945 (month) (day) (year)
Cemetery or crematory: Angel Hill
Location: Havre de Grace, Md.

18. Funeral director: F. Madeson Mitchell
Address: Havre de Grace Md.

19. 8/7 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 3 1945 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19.., to Aug. 3 1945 and that I last saw him alive on Aug. 3 1945

Immediate cause of death	DURATION
(a) Angina Pectoris	
Due to (b) Heart Block	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ... Injured at work?

23. SIGNATURE: A. L. Lewis M.D. M. D. or other
Address: Havre de Grace Md. Date signed: 8-7-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-2)

08081

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 minutes
Hospital, Institution, or street address where death occurred:
Union Ave. Harford Memorial Hosp
How long in hospital or institution? 25 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Perryman
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1184 4th St.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Baby Girl Bishop

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1945

8. AGE: Years | Months | Days | If less than one day: hrs. 25 min.

8. Birthplace Havre de Grace, Harford, Maryland
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Russel Brinkley
13. Birthplace Detroit Mich

MOTHER
14. Maiden name Geraldine Bishop
15. Birthplace Philadelphia Pa

16. Informant Miss Geraldine Bishop
Address 1184 4th St. Perry Point. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 9 1945 (month) (day) (year)
Cemetery or crematory Grave Hill
Location Harford Co
18. Funeral director P. Madison Mitchell
Address Havre de Grace, Md.

19. 8/9 1945 (Date rec'd by registrar) O. K. Lewis, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1945 at 6.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 8 1945, to Aug 8 1945
and that I last saw h. alive on Aug 8 1945

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to Lapsed Cord	1 Day
Other conditions premature rupture of membranes	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE Emma Wollerton M.D.
M. D. or other
Address Havre de Grace Date signed Aug 8

Oscar Bishop
R. F. D. Havre de Grace
Gravelly Hill

Evidence for change of age & ~~date~~ of birth of deceased is shown on FILM No. G 97 SEP 5 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-e) C

CERTIFICATE OF DEATH

08082

Reg. Dist. No. 185

1. PLACE OF DEATH:

County: Harford

City or town: Havre De Grace (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 hours

Hospital, institution, or street address where death occurred: Harford Memorial

How long in hospital or institution? 20 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infante give residence of mother)

State: Md. County: Cecil

City or town: Colora (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Joseph James Brown.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 21, 1936 ~~1938~~

8. AGE: Years	Months	Days	If less than one day
7 ~~8~~	8-5	5	hrs. min.

9. Birthplace: Colora, (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Joseph Brown

FATHER — 13. Birthplace: Colora, Md.

MOTHER — 14. Maiden name: Margaret Clemens

MOTHER — 15. Birthplace: Lancaster Co. Pa.

16. Informant: Joseph Brown

Address: Colora. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 30, 1945 (month) (day) (year)

Cemetery or crematory: West Nottingham

Location: near Colora. Md.

18. Funeral director: J. Earl Tyson.

Address: Rising Sun. Md.

19. Aug. 27 (Date rec'd by registrar) 19 45 A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 27 1945 at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 26 1945, to August 27 1945 and that I last saw h... alive on August 27 1945

Immediate cause of death	DURATION
Acute Heart failure	
Due to: Dead on operating Table	
Due to: Lung Tuberculosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: E. Reys M.D. M. D. or other

Address: Harford Hosp. Date signed: 8/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

CITIES CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

08083

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newboro infants give residence of mother)

State Md County Harford

City or town Belair Md

(If outside city or towo limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Henry Butler

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 6 - 1855

8. AGE:

Years	Months	Days	If less than one day
89	10	5	...hrs. ...min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Lecturer

11. Industry or business —

FATHER

12. Name Unknown

13. Birthplace "

MOTHER

14. Maiden name Unknown

15. Birthplace "

16. Informant Hospital Records

Address Havre de Grace - Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 13/45 (month) (day) (year)

Cemetery or crematory Hendon's Hill

Location Belair Rural

18. Funeral director Dean & Foster

Address Belair Md

19. Aug 11 1945 (Date received by registrar) A. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1945, at 1.50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 9 1945 to Aug 11 1945 and that I last saw h[illegible] alive on Aug 11 1945

Immediate cause of death	DURATION
Congestive Heart Failure	
Due to senile Tremor	
Due to Sclerosis	
Other conditions Gangrene	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. J. Lewis M. D. or other

Address Havre De Grace Date signed 8-11-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

68084

Reg. Dist. No. 181

1. PLACE OF DEATH:

County: Harford

City or town: Aberdeen R. 7 D. 2 Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro tnfants give resideoce of mother)

State: Maryland County: Harford

City or town: Havre de Grace
(If outside city or towo limits, write RURAL and givn nearest town)

Street No. 556 Lewis St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John W. Christy

3.(b) Social Security Number 716-01-8208

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of husband or wife: Nettie R. Christy

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 25, 1887

8. AGE: Years	Months	Days	If less than one day
57	8	20	..... hrs. ..... min.

9. Birthplace: Aberdeen, Harford, Md.
(Town, county, and state)

10. Usual occupation: Tractor Operator

11. Industry or business: Penna Railroad Co.

FATHER
12. Name: Isaac F. Christy
13. Birthplace: Aberdeen, Maryland

MOTHER
14. Maiden name: Susie Warfield
15. Birthplace: Aberdeen, Maryland

16. Informant: Mrs Susie Christy
Address: Aberdeen R.F.D. 2, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 25, 1945 (month) (day) (year)

Cemetery or crematory: Mount M.E. Cemetery

Location: Aberdeen, Maryland

18. Funeral director: Elmer E. Bedlock

Address: 556 Lewis St. Havre de Grace, Md.

19. Aug. 23 1945 (Date rec'd by registrar) Nellie F. Tilley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20 1945, at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20 1945 to Aug 20 1945 and that I last saw him alive on Aug 20 1945

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to: Arteriosclerosis	6 Yrs
Due to:	
Other conditions	

(Include pregnancy wtthin 3 mooths of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Pleaso underline the canse to which death shonld bo charged statistically.

22. VIOLENCE: If death wae due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James Willett M.D.
M. D. or other

Address: Havre de Grace Date signed Aug 22 1945

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08441

CERTIFICATE OF DEATH

Reg. Dist. No. 184

1. PLACE OF DEATH:
County: Harford
City or town: Dublin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 68 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Dublin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Rose E Connor

3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John Connor
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 5, 1876

8. AGE: Years	Months	Days	If less than one day
68	8	22	hrs. min.

9. Birthplace: Harford Co., Md
(Town, county, and state)
10. Usual occupation: House work
11. Industry or business: At Home

FATHER
12. Name: David Routzer
13. Birthplace: Harford Co., Md.

MOTHER
14. Maiden name: Jane Lozier
15. Birthplace: Harford Co., Md.

16. Informant: Mr John Connor
Address: Dublin, Md. R. No. 1

17. Burial (Burial, cremation, or removal—which?) Date thereof: Aug 30 1945 (month) (day) (year)
Cemetery or crematory: Dublin Cem.
Location: Harford Co., Md.

18. Funeral director: H. L. Bailey
Address: Darlington, Md.

19. Aug. 28, 1945 (Date rec'd by registrar) M. A. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 28 1945 at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1944 to Aug 27 1945
and that I last saw her alive on Aug 30 1945

Immediate cause of death	DURATION
Concussion of Cerebrum	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F. L. Snodgrass M. D. or other
Address: Darlington Date signed: 8/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137a)

CERTIFICATE OF DEATH

08085

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Rural- Bel Air
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Eight days
Hospital, Institution, or street address where death occurred:
Fountain Green Hospital, Bel Air, Md.
How long in hospital or institution? Eight Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME
John Crow

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife: Elizabeth Crow
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 15, 1865

8. AGE: Years	Months	Days	If less than one day
79 years	11	13	hrs. min.

9. Birthplace: Harford County, Md.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Farming

FATHER
12. Name: Stephen Crow,
13. Birthplace: Ireland

MOTHER
14. Maiden name: Bridget Welsh
15. Birthplace: Ireland

16. Informant: Mrs. Milton Kelly,
Address: Hickory, Md.

17. Burial (Burial, cremation, or removal) Which? Date thereof: Aug. 30, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Erin
Location: Havre de Grace, Md.

18. Funeral director: Hornberger & Gross,
Address: Benson, Md.

19. 8.29 1945 (Date rec'd by registrar) Priscilla Fawood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 28 1945 at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1944 to August 28 1945 and that I last saw him alive on August 28 1945

Immediate cause of death	DURATION
Chronic pyelo-nephritis	1 yr.
Due to: Prostatic Hypertrophy and Urinary Retention (Prostatectomy- 1945)	?
Due to:	
Other conditions: Gen. Arterio-sclerosis Chr. Myocardial Disease	

(Include pregnancy within 3 months of death)

Major findings of operations: Benign Hypertrophy Prostate.
Date of op. Mar. 1945
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other
Address: Forest Hill Md Date signed: 8/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

18186

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford Co
City or town: Fallston Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 5 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Fallston
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Eva M. H. Davis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: A. Elmer Davis
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 10 - 1888

8. AGE: Years	Months	Days	If less than one day
56	10	21	____ hrs. ____ min.

9. Birthplace: Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: David Harlan
13. Birthplace: Md.
MOTHER 14. Maiden name: Clara Riddle
15. Birthplace: Md.
16. Informant: A. Elmer Davis
Address: Fallston Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 3-1945 (month) (day) (year)
Cemetery or crematory: Friends Cemetery
Location: Fallston Md
18. Funeral director: Clarence E. Arthur
Address: Fork Md.
19. 8-2- 1945 (Date rec'd by registrar) Priscilla Fawcett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 1 1945, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 1944, to Aug 1, 1945
and that I last saw h[illegible]ative on June 31 1945

Immediate cause of death	DURATION
(a) Arterio Sclerotic Heart Disease	8 yrs
Due to:	
Due to:	
Other conditions: Malnutrition	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury: ____ Injured at work?

23. SIGNATURE: Clifford F. Hudson MD
M. D. or other
Address: Fork Date signed: 8-2-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH 08087

1190

1. PLACE OF DEATH

County Harford Registration Dist. No. 182

Village or City Bel Air No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Hazel Davis -

(a) Residence: No. St., Ward Bel Air, Md.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	Negro	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) March 30, 1945

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	17	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Bel Air, Md.

FATHER

13. NAME Miller Davis -

14. BIRTHPLACE (city or town) (State or country) Darlington, S.C.

MOTHER

15. MAIDEN NAME Lizzie Hamilton

16. BIRTHPLACE (city or town) (State or country) Darlington, S.C.

17. INFORMANT Miller Davis
(Address) Bel Air Md.

18. BURIAL, CREMATION, OR REMOVAL
Place Rendon Hill Md Date Aug 17 '45

19. UNDERTAKER Russell Lewis
(Address) 16 Howard St. Bel Air

20. FILED 8-16, 1945 Priscilla Fawood
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Aug (Month) 16th (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Aug. 14th, 1945, to Aug. 16th, 1945

I last saw her alive on Aug. 16th, 1945; death is said to have occurred on the date stated above, at m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Entero-colitis -	Aug 13. '45

Other **Contributory Causes** of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or Injury in any way related to occupation of deceased? No

If so, specify

(Signed) A. F. Van Hobbs M. D.

(Address) Bel Air, Md.

M

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94(2)

CERTIFICATE OF DEATH

08088

Reg. Dist. No. 181

1. PLACE OF DEATH

County: Harford

City or town: Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

Street No. 125 Edmond

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Rhoda Nora Davis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Enos N. Davis

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Apr 7, 1870

8. AGE:

Years	Months	Days	If less than one day
75	4	3	...hrs. ...min.

9. Birthplace: Harford Co. Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Samuel Norris

13. Birthplace: Maryland

MOTHER 14. Maiden name: Fannie Sanders

15. Birthplace: Maryland

16. Informant: Enos N. Davis

Address: Aberdeen Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 13, 1945 (month) (day) (year)

Cemetery or crematory: Union Chapel

Location: Wilna Maryland

18. Funeral director: Howard L. McComas & Son

Address: Abingdon Maryland

19. Aug. 13 19 45 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 10 19 45, at 12:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 19 45, to Aug 10 19 45

and that I last saw h...a alive on Aug 10 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to: Angina Pectoris	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury Injured at work?

23. SIGNATURE: G. B. Jonston M.D. M. D. or other

Address: Aberdeen Md. Date signed Aug 12, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

08089

CERTIFICATE OF DEATH

Reg. Diat. No. 182

1. PLACE OF DEATH:
County Harford
City or town Bel Air, Md. Rural
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Rural - Bel Air
(If outside city or town limits, write RURAL and give nearest town)
Street No. Hickory
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles H. Heck

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Grace Heck

6.(c) If alive, give age: Alive years

7. Birth date of deceased (mo., day, yr.): Aug. 30 1876

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68	11	17		

9. Birthplace: Harford Co. Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Dairy

FATHER
12. Name: Christian H. Heck
13. Birthplace: Harford Co. Md.

MOTHER
14. Maiden name: Jennie L. Hazlett
15. Birthplace: Harford Co. Md.

16. Informant: Mrs. Grace Heck
Address: Bel-Air, Md R. D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 19 1945 (month) (day) (year)
Cemetery or crematory: Broad Creek Cem.
Location: Harford Co. Md.

18. Funeral director: H. L. Bailey
Address: Darlington, Md.

19. 8. 18 1945 (Date rec'd by registrar) Priscilla Tolliver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 17th 1945, at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1944, to Aug 17 1945 and that I last saw him alive on Aug 17 1945

Immediate cause of death	DURATION
Carcinoma of Descending Colon	2 yr?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hedrone M. D. or other
Address: Forest Hill, Md Date signed: 8/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

08091

★ Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Bel Air, Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Harford

City or town: Harrunde Grace, Md (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Fairy Bell Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Married

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE:

Years	Months	Days	If less than one day
Unknown			..... hrs. ..... min.

9. Birthplace: Ga. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Unknown

13. Birthplace "

MOTHER — 14. Maiden name: Unknown

15. Birthplace "

16. Informant: Peter Records

Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 25/45 (month) (day) (year)

Cemetery or crematory: Country Home

Location: near Bel Air Md

16. Funeral director: Deane & Foard

Address: Bel Air Md

19. 8-24-45 (Date rec'd by registrar) Priscilla Forwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 23 1945, at 11:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Coronary occlusion — DURATION: —

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Gerald C Palmer M.D. Deputy Medical Examiner Harford County M. D. or other

Address: Bel Air, Md Date signed: 8/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

08092

Reg. Dist. No. 184

1. PLACE OF DEATH:
County: Harford
City or town: Whitford (R.D. Delta Pa)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Whitford (R.D. Delta Pa)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Graceton
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Lewis Everett Douglas Leonard

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	single

8.(b) Name of husband or wife: none

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 26 1945

8. AGE: Years | Months | Days: 8 | If less than one day: hrs. min.

9. Birthplace: Whitford, Harford, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Lewis Vernon Leonard
13. Birthplace: Harford Co. Md.

MOTHER
14. Maiden name: Edith Rosella Douglas
15. Birthplace: Harford Co. Md.

16. Informant: Lewis V. Leonard
Address: Whitford Md. (R.D. Delta, Pa.)

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 8 1945 (month) (day) (year)

Cemetery or crematory: Mt. Zion Cem

Location: Delta, Pa.

18. Funeral director: Hubert P. Hankins

Address: Delta, Pa.

19. Aug 8 1945 Carl E. Knoop
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8 1945, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 26 1945 to Aug 8 1945 and that I last saw h. alive on Aug 8 1945

Immediate cause of death: Thrombosis — DURATION: 2 days

Due to:

Due to:

Other conditions: Prematurity, (5mo)

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jonah G. Hunt M.D.
M. D. or other

Address: Cardiff, Md. Date signed: 8/8/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

CITIES INCORPORATED LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (152)

CERTIFICATE OF DEATH

08093

★ Reg. Dist. No. 185

1. PLACE OF DEATH

County Harford

City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred: Union Ave. Harford Mem. Hosp.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

Street No. 556 Franklin St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Reed Lissberger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Joseph Lissberger 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 1940 6-3-1903

8. AGE: Years	Months	Days	If less than one day
40	2	19	..... hrs. ..... min.

9. Birthplace Long Branch, N. J.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Frank Elberson
13. Birthplace N. J.

MOTHER
14. Maiden name Mae Davis
15. Birthplace N. J.

16. Informant Katherine Elberson
Address 625 Fountain St. Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/17/45 (month) (day) (year)

Cemetery or crematory Glenwood

Location West Long Branch N.J.

18. Funeral director Pennington & Son

Address Havre de Grace, Md

19. Aug 15 19 45 A. L. Lewis M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 19 45 at 7:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 8 19 45 to Aug 15 19 45

and that I last saw h... alive on Aug 15 19 45

Immediate cause of death	DURATION
Impetigo Contagiosa	
Pneumonia Acute	
Due to: Cellulatus Left Arm	
Septicemia	
Due to:	
Other conditions: Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Charles J. Foley M.D.
M.D. or other

Address Havre de Grace Date signed Aug 15 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

68694

CERTIFICATE OF DEATH

Reg. Dist. No. 184

1. PLACE OF DEATH:
County: Harford
City or town: Bardiff (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penna. County: Delaware
City or town: Drexel Hill, Pa. (If outside city or town limits, write RURAL and give nearest town)
Street No. 2212 Haverford Ave. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Chester C. Love

3.(b) Social Security Number: 197-10-7115

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mabel J. Love
6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): Sept. 9, 1903

8. AGE: Years	Months	Days	If less than one day
41	11	21	...hrs. ...min.

9. Birthplace: Danville, Pa. (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Soil conservation
FATHER 12. Name: Charles Love
13. Birthplace: — Penna.
MOTHER 14. Maiden name: Josephine Ferle
15. Birthplace: — Penna.
16. Informant: Mabel J. Love
Address: Drexel Hill, Penna.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 1- 1945 (month) (day) (year)
Cemetery or crematory: Slate Ridge cemetery
Location: Delta, Pa.
18. Funeral director: Hubert P. Hutchison
Address: Delta, Pa.
19. Sept. 1 (Date rec'd by registrar) 1945 Earl E. Knapp, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 30 1945, at 3:15 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 1945, to August 30 1945
and that I last saw h... alive on August 29 1945

Immediate cause of death	DURATION
Intracranial Brain Tumor	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Benjamin Boorse M.D. M.D. or other
Address: Cardiff, Md. Date signed: 8-31-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

08695

CERTIFICATE OF DEATH

★ Reg. Dist. No. 185

1. PLACE OF DEATH

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 yrs. mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 607 Green

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Clarence Arthur McCommons

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Margaret B. McCommons

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 24, 1884

8. AGE: Years	Months	Days	If less than one day
61	4	8	..... hrs. ..... min.

9. Birthplace Upper Cross Roads Harford Co.

(Town, county, and state)

10. Usual occupation Building Contractor

11. Industry or business

FATHER 12. Name Eli J. McCommons

13. Birthplace Harford Co. Md.

MOTHER 14. Maiden name Sarah A. Moffett

15. Birthplace Harford Co., Md.

16. Informant Margaret B. McCommons

Address 607 Green St., Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/11/45 (month) (day) (year)

Cemetery or crematory Angel Hill

Location Havre de Grace

18. Funeral director Pennington & Son

Address Havre de Grace

19. 8/13 19 45 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 8, 1945 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1943, to Aug 8 1945

and that I last saw h.. alive on Aug 8 1945

Immediate cause of death	DURATION
Coronary Thrombosis	
Chronic Myocarditis	
Due to Chronic Nephritis	
Due to Arterio Sclerosis.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Charles J. Foley M.D.

M. D. or other

Address Havre de Grace Md. Date signed 8/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

08090

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

CERTIFICATE OF DEATH

Reg. Dist. No. 125

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, Institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Aberdeen, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Box 163
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Laura A. Mc Fadden

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 10/1/43

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
~~23 mos~~	11			

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Infant
11. Industry or business
FATHER 12. Name: John F. Mc Fadden, Jr.
13. Birthplace: Aberdeen, Md.
MOTHER 14. Maiden name: Evelyn Styer
15. Birthplace: Maryland (Cecil County)
16. Informant: John F. Mc Fadden Jr.
Address: Box 163 Aberdeen, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 31-1945 (month) (day) (year)
Cemetery or crematory: Oakes
Location: Near Aberdeen Md.
18. Funeral director: Henry Fanning Sons
Address: Aberdeen Md.
19. Aug. 30 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 28 1945 at 4.55 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coma — Asphixia	2
Due to: Toxemia	
Due to: Ascariasis (Intestinal Parasites)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gerald C. Palmer M.D.
Deputy Medical Examiner
Harford County
M. D. or other
Address: Box A Aberdeen, Md. Date signed: 8/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

08097

CERTIFICATE OF DEATH

★ Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford

City or town Rural Bel Air
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5-6 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Harford

City or town Rural Bel Air
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME William O. Michael

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband~~ wife Ida Bell Gillett

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 8-1860

8. AGE: Years	Months	Days	If less than one day
85	7		..... hrs. ..... min.

9. Birthplace Aberdeen Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name John Calvin Michael

13. Birthplace Aberdeen Harford Co. Md

MOTHER 14. Maiden name Emma Martha Mitchell

15. Birthplace Havre de Grace Harford Co Md

16. Informant Georgie B. Michael

Address Bel Air Md

17. Buried (Burial, cremation, or removal, Which?) Date thereof Aug. 18-1945 (month) (day) (year)

Cemetery or crematory Churchville

Location Churchville Harford Co

18. Funeral director Henry Fanning Sons

Address Aberdeen Md

19. 8.17. 1945 Priscilla Forwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15. 1945, at 4:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 1943, to Aug 15 1945 and that I last saw h~~im~~ alive on Aug. 15 1945

Immediate cause of death	DURATION
Carcinoma Prostate	18 Mos
Carcinoma Sigmoid Colon	2 yrs?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Willard P Hudson M. D. or other

Address Forest Hill Md Date signed 8/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

0844E

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 183

1. PLACE OF DEATH:

County: Harford

City or town: Fallston

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Fallston R.D. 1

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Edna Mae Neal

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Wm. E. Neal

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): March 4 1890

8. AGE: Years: 55 | Months: 5 | Days: 13 | If less than one day: hrs. min.

9. Birthplace: York Co. Pa. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Housekeeping

FATHER — 12. Name: W. J. Bellistafe

FATHER — 13. Birthplace: Fairville Pa.

MOTHER — 14. Maiden name: Mollie Lloyd

MOTHER — 15. Birthplace: Gotsbille York Co. Pa.

16. Informant: Wm. E. Neal

Address: Fallston Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 28 1945 (month) (day) (year)

Cemetery or crematory: M.E. Cemetery

Location: Fairville York Co. Pa.

18. Funeral director: H. Howard Welsh

Address: Fawn Grove Pa.

19. Aug 28 1945 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25 1945 at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 25 1945 to Aug. 25 1945 and that I last saw h[illegible] alive on Aug. 25 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Causing sudden death	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Vallie Hawkins M.D. M. D. or other

Address: Fawn Grove Pa. Date signed: Aug 28 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(1)

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

08096

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Union Ave Harford Memorial Hosp.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Harford

City or town Churchville (If outside city or town limits, write RURAL and give nearest town)

Street No. Bel Air R. D. #1 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Leona Ellen Parks

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1944

8. AGE: Years | Months 9 | Days 23 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Glenn Cicero Parks

13. Birthplace Flat Ridge Va

MOTHER 14. Maiden name Ellen Parks

15. Birthplace Flat Ridge Va

16. Informant Glenn C. Parks

Address Churchville, Bel Air R.D. #1 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 29 1944 (month) (day) (year)

Cemetery or crematory West Hoffman Cemetery

Location Rising Sun, Cecil Co. Md

18. Funeral director Howard K. McComas Son

Address Abingdon Maryland

19. 8-27 1945 C. L. Lewis M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1945 at 2:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1944 to Aug 1945

and that I last saw her alive on Aug 25 1945

	DURATION
Immediate cause of death Infectious Diarrhoea	4 days
Due to	
Due to	
Other conditions Baby diarrhea	2 days.

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE I. Ralph Horky M.D. M. D. or other

Address Churchville Md Date signed Aug 27

08443

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 183

1. PLACE OF DEATH:
County: Harford
City or town: Fallston (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Fallston Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Nathan Elmer Scarborough

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife: Nannie Hall Robinson
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Sept 22 1863

8. AGE:	Years	Months	Days	If less than one day
	81	11	7	...hrs. ...min.

9. Birthplace: Cooptown Harford Co Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Retired
FATHER 12. Name: Edmund Scarborough
13. Birthplace
MOTHER 14. Maiden name: Sarah
15. Birthplace
16. Informant: Edmund R Scarborough
Address: Fallston Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 27 45 (month) (day) (year)
Cemetery or crematory: Little Falls Meeting House
Location: Fallston Harford Co Md.
18. Funeral Director: Martin G Hurst
Address: Jarrettsville, Md.
19. Aug 27 1945 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 24 19 45, at 6.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 5 1942, to Aug 25 1945 and that I last saw him alive on Aug 24 1945.

Immediate cause of death	DURATION
Hypostatic Pneumonia	4 da
Due to: Hemiplegia (Cerebral Hemorrhage) 3 attacks	5 yr
Due to:	
Other conditions: Excessive decubitus ulceration	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other
Address: Forest Hill Md. Date signed: 8/25/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08098

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:
County: Harford
City or town: Rural - Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 54 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Rural - Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. Carsins Run
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME John George Schantz Sr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary E. Ritter
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1856

8. AGE:

Years	Months	Days	If less than one day
88	8		hrs. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Germany

16. Informant: Mrs. Mary M. Gilbert
Address: Aberdeen, R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 30 1945 (month) (day) (year)
Cemetery or crematory: St Paul Lutheran
Location: Nr. Perryman, Md
18. Funeral director: Henry Tarring & Sons
Address: Aberdeen, Md.

19. Aug 30 1945 (Date rec'd by registrar) Nellie F. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 27 1945, at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1942 to Aug 27 1945
and that I last saw him alive on Aug 27 1945

Immediate cause of death	DURATION
Acute pulmonary edema	2 days
Due to: Arteriosclerotic C.V. Disease	4 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. Ralph Horky M.D.
M. D. or other
Address: Churchville Md Date signed: Aug 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS OF

08099

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Union Ave Harford Memorial Hosp
How long in hospital or institution? 3 Mo. 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. Box 219 (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Herschel Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Jessie Smith
6.(c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) Dec 16 1904

8. AGE: Years	Months	Days	If less than one day
40	8	9	..... hrs. ..... min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual occupation Crane Operator
11. Industry or business
FATHER 12. Name Hayden Lewis Smith
13. Birthplace W. Va.
MOTHER 14. Maiden name Mary Alice Lloyd
15. Birthplace W. Va.
16. Informant Mrs. Jessie Smith
Address Aberdeen Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof Aug. 9 1945 (month) (day) (year)
Cemetery or crematory Moorefield
Location Moorefield W. Va.
18. Funeral director Henry Fanning Stores
Address Aberdeen Md.
19. 8/9 1945 (Date rec'd by registrar) O. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1945 at 5:25 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/3/45 1945, to 8/7/45 1945 and that I last saw h.. alive on August 7 1945

Immediate cause of death	DURATION
Due to Pericarditis with Effusion	
Due to T. B. C	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. J. Smith M. D. or other
Address Havre de Grace Date signed 8-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08100

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County: Harford

City or town: Fallston md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Fallston

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Walter M Smith

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Lillian M. Smith

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 16 1863

8. AGE: Years: 82 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business:

FATHER 12. Name: Smith

13. Birthplace:

MOTHER 14. Maiden name: Ellen ?

15. Birthplace: ?

16. Informant: Mr Henry Smith

Address: Upper Falls Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-25-45 (month) (day) (year)

Cemetery or crematory: Friendship

Location: Fallston Md

18. Funeral director: Hamberger & Gross

Address: Benson Md

19. 8-24 1945 (Date rec'd by registrar) Priscilla Forwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 23 1945 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 11 1945 to Aug 23 1945 and that I last saw him alive on Aug 23 1945

	DURATION
Immediate cause of death: Hemiplegia	11 days
Due to: Hypertension	years
Due to:	
Other conditions: nne	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: nne

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Fred O Hodous MD M. D. or other

Address: Edgewood md Date signed: 8-23-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

08444

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:

County: Prince Georges

City or town: Bladensburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Prince Georges

City or town: Bladensburg (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John H. Tyson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Elizabeth Tyson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 24 1864

8. AGE: Years: 80 | Months: 7 | Days: 25 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore Co Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER — 12. Name: Thomas R. Tyson

FATHER — 13. Birthplace: Baltimore Md

MOTHER — 14. Maiden name: Elizabeth Eaton

MOTHER — 15. Birthplace: Baltimore Md

16. Informant: Mary R. Tyson

Address: Bladensburg Md

17. Burial, cremation or removal. Which?: Burial Date thereof: Aug 21 1945 (month) (day) (year)

Cemetery or crematory: Farm Grove

Location: Farm Grove Pa

18. Funeral director: H. Howard Keller

Address: Farm Grove Pa

Aug 21 1945 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18 1945, at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1945 to Aug 17 1945 and that I last saw him alive on Aug 17 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Arterio-sclerosis	7 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Edward H. Tyson M. D. or other

Address: Farm Grove, Pa. Date signed: 8/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

08101

Reg. Diat. No. 181

1. PLACE OF DEATH:

County: Harford

City or town: Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 42 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Aberdeen Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 31 E. Bel Air Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Frederick Owen Viele

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Eunice Jamison

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Aug. 13 - 1876

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68	11			

9. Birthplace: Troy Pa (Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: Retail Lumber business

FATHER

12. Name: Giles F. Viele

13. Birthplace: N.Y.

MOTHER

14. Maiden name: Florance Arden

15. Birthplace: Troy Pa

16. Informant: Mrs. Eunice J. Viele

Address: #31 E. Bel Air Ave Aberdeen Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 16 - 1945 (month) (day) (year)

Cemetery or crematory: Grove

Location: Aberdeen Md.

18. Funeral director: Gregg Fanning Sons.

Address: Aberdeen Md.

19. Aug 10 1945 (Date rec'd by registrar) Nellie W. Giles Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 8 1945, at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1945, to Aug 8 1945 and that I last saw h m alive on Aug 7 1945

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H K Delaney M.D. (M. D. or other)

Address: Aberdeen Md Date signed: Aug 9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

08102

Reg. Diat. No. 181

1. PLACE OF DEATH:

County: Harford

City or town: Perryman (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Perryman (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Laura G. Wells

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: James F. Wells

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 15th 1870

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
74	9			

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: William F. Bevans

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Laura C. ?

MOTHER — 15. Birthplace: Maine

16. Informant: Mrs. Robert E. Wells

Address: 318 N. Longwood Ave. Balto. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 6 1945 (month) (day) (year)

Cemetery or crematory: Abingdon No. 5

Location: Abingdon Harford Co. Md

18. Funeral director: Henry Fanning Sons

Address: Aberdeen Md

18. Aug. 4 1945 (Date rec'd by registrar) Nellie F. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 3rd 1945, at 3.25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 6th 1945, to Aug. 3 1945

and that I last saw her alive on August 3 1945

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to: Chronic Cholelithiasis	
Due to: Chronic Cholecystitis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Howard D. Holloway M. D. or other

Address: Perryman, Md Date signed: Aug. 4 '45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 37

08103

CERTIFICATE OF DEATH

Reg. Diat. No. 185

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace

(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 8 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Bel Air

(If ontside city or town limits, write RURAL and give nearest town)

Street No.: The Colonial Rooming House

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: J. Edward Wharton

3. (b) Social Security Number: 270-09-7219

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Rose Swiggett

B.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): August 4, 1883

8. AGE: Years	Months	Days	If less than one day
62			hrs. min.

9. Birthplace: Walkersville, Md. Co. Md.

(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Cabinet Maker

FATHER — 12. Name: Wm. Henry Wharton

13. Birthplace: Greensburg, Penna

MOTHER — 14. Maiden name: Ellen J. Shaver

15. Birthplace: Walkersville, Md.

16. Informant: Mrs. Daisy Betts (Sister)

Address: Bel Air, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 25/45 (month) (day) (year)

Cemetery or crematory: Interment

Location: Port Clinton, Ohio

18. Funeral director: Dean & Foster

Address: Bel Air Md

19. Aug. 23 19 45 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-22 19 45 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-17-45 19 to 8-22 19 45 and that I last saw him alive on 8-22 19 45

	DURATION
Immediate cause of death: Lobar Pneumonia	
Due to: Toxemia - Asphyxia	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: E. Reya Cox M. D. or other

Address: Harford Mem. Hospital Date signed: 8/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

* 08104

Reg. Dist. No. 180

1. PLACE OF DEATH:
County: Harford
City or town: Magnolia
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr - 1mo.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penna. County: Schuylkill
City or town: Pottsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Frederick Winn

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Carrie E. Winn
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 25, 1880

8. AGE: Years	Months	Days	If less than one day
65	6	9	hrs. min.

9. Birthplace: Pottsville Pa.
(Town, county, and state)

10. Usual occupation: Retired Coal Miner

11. Industry or business

FATHER
12. Name: Henry Winn
13. Birthplace: Germany

MOTHER
14. Maiden name: Elizabeth Miller
15. Birthplace: Pa.

16. Informant: Mrs. Violet C. Miller
Address: Magnolia Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug. 7 1945 (month) (day) (year)
Cemetery or crematory: Claude A. Lord
Location: 410 Garfield Square, Pottsville, Pa.

18. Funeral director: Howard K. McComas & Son
Address: Abingdon Md.

19. Aug. 7 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 4 1945 at 7.50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 1944 to Aug 4 1945 and that I last saw h... alive on Aug 4 1945

Immediate cause of death	DURATION
Silicosis	2 mos
Bronchiectasis	Years?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Ned V Hodous M.D.
M. D. or other
Address: Edgewood Md. Date signed: 8-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15